

2.0 Project Description

Many women in the United States still do not receive routine cervical and breast cancer screening according to recommended intervals, despite their proven effectiveness to reduce morbidity and mortality. These women are more likely to be poor, uninsured, lack a usual source of health care, and reside in rural areas of the U.S. To reduce cancer health disparities among women *rarely* or *never* screened for cervical and breast cancer, a *public-private partnership* developed in 2001 between three Federal agencies; the Centers for Disease Control (CDC), the National Cancer Institute (NCI) and the United States Department of Agriculture (USDA) and one non-profit agency the American Cancer Society (ACS). Together, the *public-private partnership* initiated a demonstration pilot program in 2003 with regional and local public health practitioners, *stakeholders* from eight Appalachian states. These sites were chosen because they represented states with the highest cervical and breast cancer morbidity and had the lowest screening rates for these cancers.

A substantial amount is known about how to successfully increase cervical and breast cancer screening, and for many years researchers have assumed that an intervention deemed efficacious within a research environment could be easily diffused to the field; unfortunately this has not been the case. Very little is known about how best to disseminate evidence-based intervention approaches so they can be widely implemented at the community level. Disseminating sound research evidence involves a triangle that includes dedicated partnerships that embrace population-based health principles, the best available scientific interventions, and practitioners willing to adopt or adapt new approaches. To encourage widespread adoption of research-tested interventions the CDC, NCI, USDA and ACS partnered to develop and implement a training program and follow-up activities to promote collaboration among local partners and to disseminate evidence-based interventions.

3.0 Partnership Goal

The *goal of the public-private partnership* is to increase participation in cervical and breast cancer screening programs among *never* and/or *rarely* screened women living in United States counties with persistently high cervical and breast cancer incidence and mortality.

3.1 Evaluation Objective

The *overarching objective* of this evaluation is to determine whether a novel *public-private partnership* is able to implement and sustain a demonstration pilot program among eight states. A contractor is solicited in order to assess this objective; a process, impact and outcome evaluation is planned. Process evaluation results are intended to provide direction for changes to a pilot program that can lead to future program improvements. The impact evaluation results will describe the short and intermediate success of the current program. These results will be used along with outcome evaluation findings to determine the future investments in this program, if they ultimately impact population-based health outcomes.

4.0 Background Material

Figure 1 depicts the national partnership's structural framework and current state team composition for the *public-private partnership* program, related partners and audience of need.

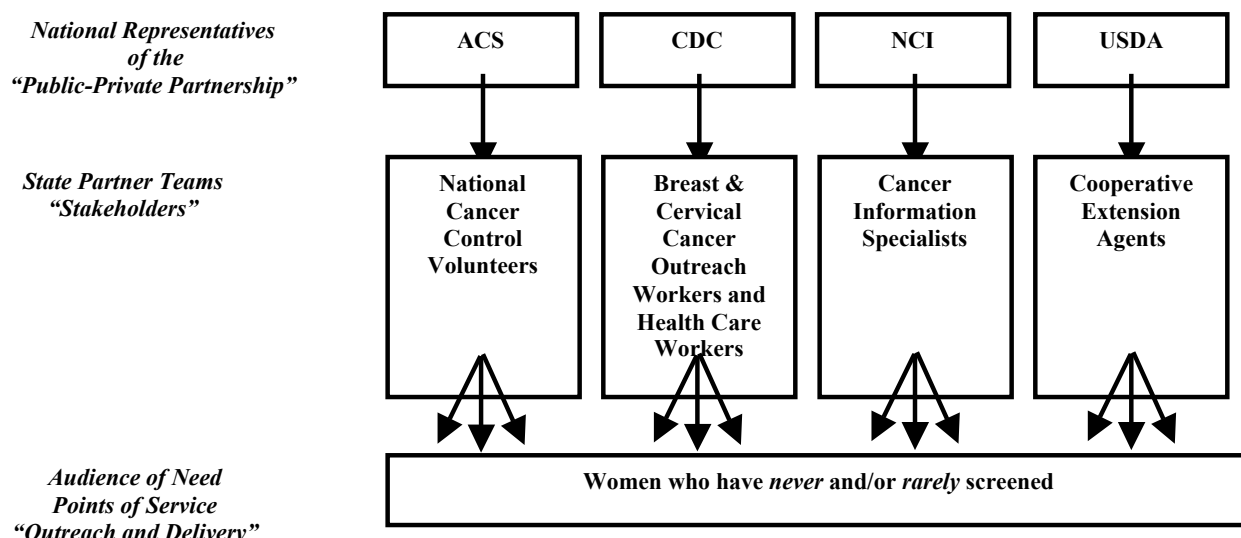


Figure 1. Public Private Partnership Structural Framework

Planning efforts commenced in a step-wise manner beginning with a concept mapping exercise, a needs assessment designed to gain consensus amongst stakeholders for establishing the guiding program objectives and direction (Attachment 1). Following this exercise, a logic model that illustrates how important underlying assumptions for this *public-private partnership* program were developed. The logic model depicts how different elements build upon each other to describe the fundamental principles of this *public-private partnership* with inputs supported by each of the partners and outcomes at each evaluation phase - process, impact and outcome. The logic model also displays the basic sequence of events from planning the program and links them through to the desired results (Attachment 2).

Before expanding the *public-private partnership* program to other states the NCI wishes to determine the value and effectiveness of a pilot program with eight identified states (Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee). To determine whether evidence-based principles are being integrated into competing state priorities and day-to-day workloads, and whether local partnerships are successful, functional, and productive a follow-up process evaluation of state teams was conducted at both 3 months and 6 months after the pilot training (Attachments 3, 4, 5). Process evaluation results are intended to provide direction for changes to the current pilot program that will enhance the effectiveness of future training, portray insight into the leadership, support programs currently in place, and potentially provide for expansion to other partners and states. Results of these process evaluation efforts will be shared with the selected contractor and should be incorporated into their work in guiding and implementing the program's evaluation efforts.

During the course of this evaluation NCI will make those program implementation decisions deemed necessary to enhance individual state team's effectiveness. The impact of these decisions should be incorporated into evaluation activities inasmuch as they pertain to short and intermediate outcomes. With this logic, efficacious and effective changes in health measures are expected. In addition, we expect to better understand why certain behavioral variables (i.e., why the leadership in some states is more effective than in other states) carry more weight than others. Outcome information will provide the 'big picture' perspective and will help determine future investments in this program by focusing on long-term goals, which will have to be tracked over a long period of time.

4.1 Description of the Pilot Training

To initiate a structured collaboration at the local level, and to encourage widespread adoption of research-tested interventions, practitioners representing the parent *public-private partnership* organizations were invited to learn about and to include evidence-based principles in their everyday work. In July and August 2003, training entitled, "*The Partnership To Increase Cervical and Breast Cancer Screening in High Mortality Counties: Pilot Training*," was held in Atlanta, Georgia. The purpose of the training was to develop and support state-level partnerships to identify, synthesize, and implement evidence-based approaches to identify and encourage women who *rarely or never have been screened* for cervical or breast cancer to be screened. Specifically, the training provided an opportunity for participating states to:

1. Understand how to access and adapt effective research-tested screening interventions for use in high mortality regions.
2. Develop, create or strengthen partnerships at the local level.

The 1-day training was attended by eight states with cervical cancer rates above the U.S. national average and included representatives from Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee. Local *stakeholder* partners included individuals from USDA Cooperative Extension agents, National Breast and Cervical Cancer Early Detection Program outreach staff, Regional Cancer Information Service Partnership Program staff, American Cancer Society Regional planners and other practitioners or educators from the identified states.

Recognizing that widespread awareness and adoption of these evidence-based principles could have a profound impact on public health education and practice and, ultimately, on the public's health, the training utilized a variety of methods and formats. These included formal presentations by cancer control experts with information on data describing state-level cervical and breast cancer mortality, and a demonstration of and instruction on accessing evidence-based screening interventions using tools such as the *Cancer Control PLANET* (Plan, Link, Act, Network with Evidence-based Tools) web portal (<http://cancercontrolplanet.cancer.gov/>). State teams engaged in small group activities, which focused on developing a shared vision of priorities for reducing cervical and breast cancer mortality rates. The primary deliverable from the training program was an Action Agenda developed by each state team. These

agendas identified priorities, potential for building local partnerships, and exploring the next steps (i.e., tasks, timelines, resources) for creating a plan in their respective states for increasing screening among women who have rarely or never been screened for cervical and breast cancer (Attachments 6, 7).

5.0 Evaluation Questions

The NCI is interested in conclusions regarding the effectiveness of the process, impact and outcome of this unique *public-private partnership*. Following are questions that should be answered in the course of this evaluation. Answers to these questions should include the result or status, as well as direction for future decisions that could enhance the effectiveness and potential expansion of the partnership beyond the current configuration.

5.1 Process Objectives:

Specific *process objectives* will assess the degree to which the *public-private partnership* is working and will:

1. Assess the multiple dimensions of the public-private partnership leaders, partner involvement, management structure, and sufficiency of resources.
2. Distinguish whether the *stakeholder* pilot training was successful, provided clear information so *stakeholders* understood training goals, were able to develop realistic action plans, and were able to effectively translate evidence-based interventions into public health practice.
3. Consider opportunities and recommendations for modifications to the pilot program to increase effectiveness of the partnership and to make recommendations for future *public-private partnerships* beyond the pilot phase. The vision is to look beyond the “one-shot” pilot program and promote long-term stakeholder involvement by mobilizing their participation and focusing on accomplished goals.

Using a model proposed by Weiss et al., (2002) it is hypothesized that specific dimensions of partnerships functioning is directly related to the specific partnership's synergy. With this focus, the emphasis is placed on collaboration, whether it works to create a system change and whether it identifies expectations about how the project should work – an “ideal type” which can then be used to assess deviations in practice (i.e., at the state level), and why these deviations have occurred, and how the deviations may affect achievements of goals either positively or negatively. Although collaboration can be tremendously advantageous, many partnerships struggle to make the most of the collaborative process and to accomplish their goals (Weiss, Anderson & Lasker, 2002). Building effective partnerships is time-consuming, resource intensive, and very difficult. However, while collaborators attempt to establish good working relationships between partners, create viable plans, and implement goals, very little is known about *how* or *why* certain collaborations work and others do not. Little is known about what enables successful partnerships to accomplish more than individuals and organizations can on their own (Weiss, Anderson & Lasker, 2002).

For instance, Lasker and Weiss (2003) point out that a key obstacle for people involved in partnerships is that the full body of knowledge about the collaboration expectations or knowledge about how to solve a particular problem is not readily available. A second key obstacle is that frequently partners and stakeholders come from different disciplines, have different interests than the funding or parent organization (i.e., the *public-private partnership*) and consequently do not have a common goal to effectively communicate with each other in the field to solve a particular problem. A third obstacle is associated with three proximal outcomes - the *characteristics of the leadership* (i.e., *public-private partnership* leaders as well as self-identified *stakeholder leaders*), *individual empowerment*, and whether *social ties are bridged* and results in *synergy*. Lasker and Weiss (2003) believe that special kinds of leaderships form, are able to collaborate with each other, and are able to be successful. These collaborations form early and are able to be sustained throughout the life of a project. Other collaborations lack effectiveness and are less successful, remain a work in progress and never realize their full potential.

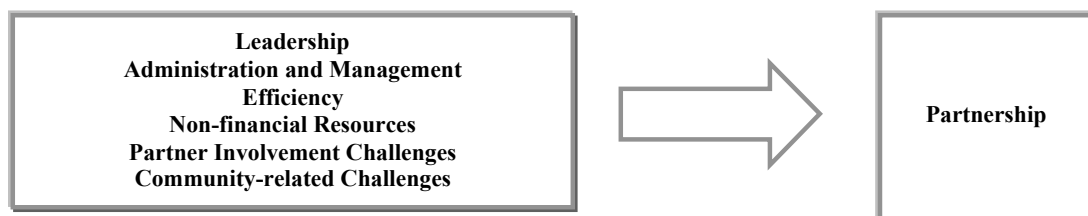


Figure 2. Dimensions of partnership functioning connected to partnership synergy

5.2 Process Evaluation Questions

Upon ascertainment of need, further data may need to be collected to understand the extent of the state *stakeholder* functioning. Some formative research processes have been gathered to provide information that is essential to the development of this ongoing collaborative relationship among state team members and related stakeholders. These processes generated qualitative data, and have monitored activities relating to *state* stakeholders only (Attachments 3, 4, 5). The contractor will, if necessary implement additional process evaluation methodologies (i.e. quantitative methods), analyze results, and provide NCI with a report on the overall strength and performance of the *public-private partnership*. Such responsibilities include but are not limited to continuing to ask questions relevant to evaluating the *process* necessary to reach women who have *rarely or never* been screened for cervical and breast cancer. The offeror is encouraged to utilize the partnership assessment variables specified within the Lasker and Weiss model. These can be found at (<http://www.cacsh.org/cresources.html>).

Activities to expand the scope of tasks associated with the process evaluation that were not previously addressed may include, but are not limited to telephone interviews or web-based questionnaires to assess the functionality of the *public-private partnership* leadership and state *stakeholder* members as described by Lasker and Weiss.

5.4 Impact Objectives

Specific *impact objectives* will focus on determining the short- and intermediate-term effectiveness of the project described in the logic model, which is ultimately of interest to society and shows the desired outcomes. Short- and intermediate impact measures of interest are:

1. *Short-term impacts* will measure whether *stakeholders* acquired specific skills, new knowledge, and perspectives to build capacity at the local level, and will document what changes occurred as a result of implementing evidence-based cancer control programs in Alabama, Georgia, Illinois, Kentucky, Mississippi, Missouri, South Carolina, and Tennessee.
2. *Intermediate-term impacts* will assess strategies *stakeholders* use to introduce, change, adapt, and incorporate research-tested cancer control approaches in the field.

5.5 Impact Evaluation Questions

The *impact evaluation* will assess the *near-term* and *intermediate-term* goals described in the logic model and draws on relevant concepts from Diffusion of Innovations theory, which describes the process through which an innovation is communicated through certain channels over time to members of a social system (Rogers, 2003). In this context, an “*innovation*” is defined as an idea, practice, or object, which is perceived as new (i.e. adoption and/or adaptation for use of evidence-based program components). Four stages of adoption of innovation are identified in the *Diffusion of Innovation* model:

1. The *knowledge* phase involves learning about the innovation.
2. The *persuasion* stage involves the individual forming positive or negative attitudes about the innovation.
3. The individual then tests the acceptability of the innovation in the *decision stage*.
4. The final stage is characterized by *adoption or rejection* of the innovation.

Diffusion of Innovations is particularly appropriate for this program because five different “adopter” categories are identified in the theory. They are: (1) early innovators, (2) early adopters, (3) early majority, (4) late majority, and (5) late adopters. Furthermore, because the July to August 2003 pilot training-program was fashioned after a train-the-trainer model the emphasis was on the *stakeholders* who were viewed as change agents. They were trained to influence the adoption of evidence-based cancer screening interventions in high mortality counties. Specific *near-term* questions are:

1. *Knowledge:*
 - a. Has knowledge and awareness of how to adopt and/or adapt evidence-based cancer screening programs increased?
 - b. Does awareness increase after being instructed on how to identify evidence-based screening interventions?
 - c. Are program goals and objectives to reach never or rarely screened women identified and agreed upon?
 - d. Which stakeholder groups are able to identify evidence-based programs and why are they able to move ahead as planned?
2. *Persuasion*
 - a. Are beliefs about evidence-based interventions integrated?
 - b. Does self-efficacy play a role in developing skills to disseminate evidence-based interventions?

Specific *intermediate* questions inquire about whether partnership *stakeholders* were able to adopt and disseminate appropriate interventions in their community. The primary questions of interest are:

1. *Decision:*
 - a. To what extent partnership stakeholders are able to increase participation in breast and cervical cancer screening programs in their community?
 - b. Identify which evidence-based screening approaches and which cancer control education strategies, products and/or materials were most effective in reaching target populations of women *never or rarely* screened for breast and cervical cancer.
2. *Adoption or Rejection:*
 - a. Identify and understand which partners are able to serve as early change agents, which are later change agents.
 - b. Describe the difference is between these individuals and their programs.

5.6 Outcome Evaluation Questions

An *outcome evaluation* will examine the *long-term* goal of whether the incidence of breast and cervical cancer is reduced in the defined eight Appalachian region states, relative to the rest of the United States. A second goal is to determine whether mortality rates for these cancers similarly decrease over time.

5.7 Outcome Objectives

The specific *outcome objectives* of this collaboration are to:

1. Identify women in high risk/high mortality counties for cervical and breast cancer who have *rarely or never* been screened.
2. Increase the probability that women in high-mortality counties will know where to go locally and become motivated to get screened and/or get care for cervical and breast cancer.

For each woman receiving a breast and/or cervical cancer screening examination, demographic characteristics, screening location and results, diagnostic procedures and outcomes will be collected. We define women who have “*never*” been screened as women obtaining their “first” screening, and women who have “*rarely*” been screened as those who have *not* received a screening within the past five years.

Data will be collected from the National Breast and Cervical Cancer Early Detection program Minimal Data Elements (MDE) database (administered by the Centers for Disease Control and Prevention). The program provides screening, referral, and follow-up services for medically underserved low-income women through health care facilities used by the general population. The formats and methods used for data collection vary among programs; however, the data categories are standardized before they are reported electronically to

CDC twice a year. A second data source to monitor changes in cervical and breast cancer screening is the Behavioral Risk Factor Surveillance Survey (BRFSS).

6.0 Specific Requirements

The contractor shall furnish the necessary labor, materials, supplies, equipment, and services (except as otherwise specified herein) to perform the work set forth below.

6.1 Mandatory Requirements

1. The Contractor shall have or be willing to establish an office located within 45 minutes commuting distance by car of the Rockville, Maryland area. The location must be such as to permit close consultation, coordination, and timeliness in all matters related to the operation of the tasks in this Task Order.
2. The Contractor shall provide two project directors.
 - a. One project director will dedicate at least 75 percent of his/her effort to overseeing, coordinating and managing the delivery of projects related to the educational programs part of this contract.
 - b. One project director will dedicate between 25 and 50 percent of his/her effort to overseeing, coordinating and managing the delivery of data to be collected.
3. Submit to NCI monthly progress reports that detail activities toward achieving tasks within this Task Order. Such may accompany invoices, which should also include detailed descriptions of the expenditure of contract funds (hours and level of staffing, material procurements, etc).

7.1 Specific Tasks

The Contractor shall perform the specific requirements listed below:

Task 1.0 Set up and Management

The contractor will initiate its relationship with NCI and members of the *public-private partnership* evaluation team with a set of activities aimed at gaining understanding in the project, its eight state *stakeholders* and past and current activities.

- | | |
|----------|---|
| Task 1.1 | Review the project and project materials and meet in person to clarify specifics related to this Task Order and discuss the work plan, requirements, expectations, deliverables and a timeline |
| Task 1.2 | Develop a communications and operation plan for working as the project evaluator. Such should include the interactions necessary to perform the tasks and the most feasible approaches for such interactions. |
| Task 1.3 | Develop and submit for review and approval a comprehensive work plan (including rigorous methodology, data collection, and analysis and reporting activities) and expected deliverables with deliver dates. |
| Task 1.4 | Submit monthly progress report to project officer(s) and schedule of routine teleconferences with the evaluation team leaders and members. |

Of particular importance in this task is the development and articulation of a methodology that is sound given the specific challenges and limitations associated with the unit(s) of measurement and sample sizes for survey development and assessment. Regarding process evaluation, state teams, which are dynamic units may optimally increase in representation but could potentially decrease in membership over the course of this evaluation program. Regarding the impact and outcome evaluation measures and indicators, the contractor will need to discuss the limitations of existing data sources and how they impact the evaluation.

Task 2.0 Evaluation Implementation

Following a brief introductory and initiation period, the contractor shall proceed with implementation of the evaluation as stated with the work plan and approved by NCI. Implementation tasks include:

- Evaluation Preparation - Develop the evaluation plan and design for the process, outcome and impact phases. Define the evaluation questions and indicators. Identify data sources, define data collection methods, develop appropriate data

collection tools and instruments as needed, develop data management plan (codebook or other tools), and data analysis plan.

- Compile a written evaluation plan for approval to the evaluation team leaders.
- Consider the necessary clearance and/or data collection approvals needed and seek to obtain them. These may include Institutional Review Board (IRB) and Office of Management and Budget (OMB) approval and clearance. Determine whether the generic OMB approval processes available through NCI and NIH are applicable to the type of data collected.

Task 2.1 Conduct and Manage Process Evaluation (Public-private partners and stakeholders):

The Contractor will perform tasks aimed at fulfilling the following set of process evaluation objectives:

Assess the multiple dimensions of the public-private partnership leaders, partner involvement, management structure, and sufficiency of resources.

Distinguish whether the *stakeholder* pilot training was successful, provided clear information so *stakeholders* understood training goals, were able to develop realistic action plans, and were able to effectively translate evidence-based interventions into public health practice.

Consider opportunities and recommendations for modifications to the pilot program to increase effectiveness of the partnership and to make recommendations for future *public-private partnerships* beyond the pilot phase. The vision is to look beyond the “one-shot” pilot program and promote long-term stakeholder involvement by mobilizing their participation and focusing on accomplished goals.

Specifically, the contractor will examine the program's current on-line communication tool and consider adapting it for use as a data collection mechanism. Utilize an on-line system with public-private partners and stakeholders that will facilitate the collection of related data in a routine, non-cumbersome manner (<http://pilotpartnershipforum.cc.gov>). Enter and analyze data and periodically report findings in order to incorporate their use in the refinement of the project.

Task 2.2 Conduct and Manage Impact Evaluation (Stakeholders):

The Contractor will perform tasks aimed at determining, using the Diffusion of Innovation framework, the degree to which state teams and stakeholders adopt the concept of using evidence-based programs or products. Specifically, the impact evaluation will assess progress through the following phases of diffusion:

- The *knowledge* phase - learning about the innovation,
- The *persuasion* stage - the forming positive or negative attitudes about the innovation.
- The decision stage - individual then tests the acceptability of the innovation, and
- The adoption or rejection stage - characterized by *adoption or rejection* of the innovation, which is the use of evidence-based products or programs.

Contractor will:

- Develop data collection instruments
- Develop theoretically based questions to assess knowledge, persuasion, decision and adoption/rejection
- Develop code book
- Develop data analysis plan
- Survey stakeholder
- Enter and analyze data and report findings.

Task 2.3 Conduct and Manage Outcome Evaluation (States and individual women):

Contractor will work with the national partners to design a methodology to assess outcomes of the partnership program. Specifically, the outcome objectives include:

- Identify women in high risk/high mortality counties for cervical and breast cancer who have *rarely or never* been screened.

- Increase the probability that women in high-mortality counties will know where to go locally and become motivated to get screened and/or get care for cervical and breast cancer.

In order to conduct and manage the outcome evaluation process, the contractor will:

- Discuss with evaluation team the structure of national data surveillance data and determine appropriate methodology for measuring screening rates in select states
- Develop and submit to NCI a proposal requesting data and defining variables of interest
- Develop data collection instrument
- Develop code book
- Develop study design
- Develop data analysis plan that includes use of Data from the National Breast and Cervical Cancer Early Detection Program (administered by the Centers for Disease Control and Prevention).

Task 2.4 Evaluation Findings and Report Generation

Contractor will develop content outline, write and revise evaluation report. Specifically:

- Provide semi-annual reports of findings from process evaluation in order to inform partnership implementation decisions.
- Report on findings for each phase of the evaluation.
- Draft a final report and submit it to the evaluation team leaders for review and feedback.
- Conduct a briefing with the evaluation team leaders to discuss evaluation findings.
- Revise the final report to include the evaluation team leader comments and submit a final report.
- Develop successive presentations (i.e. annotated PowerPoint slides) of evaluation activities and findings for use by project partners in discussions and/or scientific presentations.

7.0. Evaluation Factors

The award will be based on an evaluation of proposals against four factors. The factors in order of importance are: technical approach, past performance, and cost. Although technical factors are of paramount consideration in the award of the contract, both past performance and cost/price are also important to the overall contract award decision. All evaluation factors other than cost or price, when combined, are significantly more important than cost or price.

7.1. Understanding the Requirements and Technical Approach

The proposal must demonstrate a thorough understanding of the requirements of the Task Order and describe an approach, which will show the achievement of desired tasks and timely and acceptable performance. The offeror must describe how it will accomplish each task and the Government will evaluate the proposed plan for its soundness, practicability, and feasibility. The proposal must demonstrate a reasonable and feasible organization and staffing, and include:

1. A person-loading chart showing staff assignments and estimates of hours for each task.
2. An approach to management of the evaluation for a partnership program model where decision are made through group discussions and consensus.
3. Understanding of objectives and alignment of methodologies suited to the program,
4. Technical approach to fulfilling the tasks describe in the task order, and
5. An organizational chart delineating lines of authority.

7.1a Personnel

The Government will evaluate proposed personnel on their demonstrated and documented relevant expertise, education, availability and experience. The offeror must demonstrate experience in evaluation in general and evaluation of community outreach efforts in particular, evaluation research and design, instrument development, and overall program management. The offeror must demonstrate knowledge and/or experience in intervention research. The project director must have experience in the management and operation of

the diverse tasks required in this Task Order. The offeror must include letters of commitment from individuals not currently employed by the offeror, as well as resumes of key personnel.

7.1b Corporate Management Capability

The offeror must submit a corporate management plan, which clearly defines the lines of authority and responsibility within the organization itself and between the organization itself and the proposed project. Corporate individuals having oversight responsibility for the proposed project must be identified and appropriate quality procedures must be included.

7.1c Facilities and Equipment

The offeror shall describe in detail the availability and proposed utilization of appropriate facilities, equipment, and software systems technology to successfully perform this Task Order. This includes equipment such as telephones, facsimiles, computers, Internet access, and space for the day-to-day operations. In addition, the offeror must describe its production capacities.

7.2 Past Performance

The offeror must demonstrate recent successful experience in managing similar contracts or related work of comparable technical complexity. The government is seeking to determine whether the offeror has consistently demonstrated a commitment to customer satisfaction and timely delivery of high quality products and services. The offeror must submit a list and description of the last five contracts completed during the past three years and all contracts currently in progress that are similar in nature to this Task Order. In addition, the offeror shall include the name and telephone number of the technical point of contact.

NCI staff will contact the references provided to assess the offeror's: (1) record of conforming to specifications and standards of good workmanship; (2) adherence to contract schedules, including administrative aspects of performance; (3) reputation for reasonable and cooperative behavior and commitment to customer satisfaction; and (4) record of controlling and forecasting costs.

The evaluation will be based on information obtained from references provided by the offeror, other relevant past performance information obtained from other sources known to the Government, and any information supplied by the offeror concerning problems encountered on the identified contracts and corrective action taken. The Government will consider the currency and relevance of the information, source of information, context of the data, and general trends in the offeror's performance.

7.3 Cost/Price

Offerors are advised that award will be made to the offerors whose proposal provides the best overall value to the government.

8.0 Additional Evaluation Factors Considered

1. *Related Experience:* Contractor must show directly related experience with health related process and impact evaluation.
2. *Staffing:* Qualifications of the personnel assigned and their ability to perform the work will be evaluated.
3. *Cost:* While cost is not the most important factor, proposed prices will be considered when selecting the firm that represents the best value to the government.

9.0 References

Lasker RD and Weiss ES. Broadening Participation in Community Problem Solving: A Multidisciplinary Model to Support Collaborative Practice and Research. *Journal of Urban Health* 80:14-47, 2003.

Rogers E. Diffusion of Innovations, 2003. Free Press, New York, N.Y.

Weiss ES, Anderson R, and Lasker RD. Making the Most of Collaboration: Exploring the Relationship Between Partnership Synergy and Partnership Functioning. *Health Education & Behavior* 29:683-698, 2002.

Lasker RD, Weiss ES, and Miller R. Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage. *The Milbank Quarterly* 79:179-206, 2001.

RFTOP#

TITLE: Dissemination of Evidence-Based Interventions: Evaluation of the Public-Private Partnership to Increase Cervical and Breast Cancer Screening in High Mortality Counties

PART II - CONTRACTOR'S REPLY: CONTRACT #263-01-D-0_____ TO # NICS-_____

Contractor:

Points of Contact:

Phone-

Fax-

Address:

TOTAL ESTIMATED COST:

Pricing Method

TOTAL ESTIMATED NUMBER OF HOURS:

PROPOSED COMPLETION DATE:

FOR THE CONTRACTOR: _____

Signature

Date

SOURCE SELECTION:

WE HAVE REVIEWED ALL SUBMITTED PROPOSALS HAVE DETERMINED THIS FIRM SUBMITTED THE BEST OVERALL PROPOSAL AND THE PRICE/COST IS REASONABLE.

Billing Reference # _____

Appropriations Data: _____

(ATTACH OBLIGATING DOCUMENT IF AN ROC WILL NOT BE USED)

RECOMMENDED: _____

FAX #

Signature - Project Officer

Date

APPROVED: _____

FAX #

Signature - Contracting Officer

Date

NIH APPROVAL -

CONTRACTOR SHALL NOT EXCEED THE ESTIMATED LABOR HOURS OR ESTIMATED TASK ORDER AMOUNT WITHOUT THE WRITTEN APPROVAL OF THE CONTRACTING OFFICER & PICS COORDINATOR

APPROVED: _____

Signature – Larry Manning the NIH PICS Coordinator at 301.402.3067or manningl@od.nih.gov,

Date -